CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 675

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: SEPTEMBER 16, 2005

CHANGE REQUEST 3943

SUBJECT: Changes to Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Date October 1, 2005)

I. SUMMARY OF CHANGES: The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. These changes manualize CMS 4064- IFC, published in the Federal Register on March 8, 2005. The instructions in this change request (CR) include quality improvement and workload priorities. Other changes to the appeals process, including parties the appeals, appointment of representative, fraud and abuse, etc. will be manualized in another CR. Until the issuance of such CR, fiscal intermediaries (FIs) are to follow the current manual sections or CR 3530.

NEW/REVISED MATERIAL

EFFECTIVE DATE: October 1, 2005

IMPLEMENTATION DATE: October 3, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:

R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	29/Table of Contents
N	29/350/Workload Data Analysis Program
N	29/360/Managing Appeals Workloads
N	29/360.1/Standard Operating Procedures
N	29/360.2/Execution of Workload Prioritization
N	29/360.3/Workload Priorities

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 675	Date: September 16, 2005	Change Request 3943

SUBJECT: Changes to Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Date October 1, 2005)

I. GENERAL INFORMATION

A. Background: The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. This new "reconsideration" is different from the previous first level of appeal for Part A claims performed by fiscal intermediaries (FIs). Reconsiderations will be processed by qualified independent contractors (QICs).

B. Policy: The purpose of this CR is to notify FIs and carriers about the upcoming transition to the new second level of the appeals process. For Part A and Part B redeterminations issued and mailed by FIs on or after May 1, 2005, the parties to the redetermination will have the right to appeal to a QIC. For Part B redeterminations issued and mailed by carriers on or after January 1, 2006, the parties to the redetermination will have the right to appeal to a QIC. All FI redeterminations issued and mailed before May 1, 2005 will have appeal rights to the administrative law judge for Part A claims and to the hearing officer (HO) for Part B claims. All carrier redeterminations issued and mailed before January 1, 2006 will have appeal rights to the HO for Part B claims.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3943.1	The FI or carrier shall perform data analysis, at a minimum, on a monthly basis.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3943.2	The FI or carrier shall perform data analysis for each contractor site.	x	x	x	x					
3943.3	The FI or carrier shall perform data analysis on either the entire universe of redeterminations or a 10 percent or 100 per month randomly selected example of redeterminations.	x	x	x	x					
3943.4	At times during limited resources, the contractor shall prioritize the processing of appeals in accordance with §360.	x	x	x	x					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	Provider education is not needed.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2005 **Implementation Date:** October 3, 2005 **Pre-Implementation Contact(s):** Tara Boyd at 410-786-2069 or Jennifer Frantz at 410-786-9531 **Post-Implementation Contact(s):** Contact your local regional office	**Funding for implementation activities will be provided to contractors through the regular budget process.**

Medicare Claims Processing Manual
Chapter 29 - Appeals of Claims Decisions

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(Rev.675, 09-16-05)

350 - Workload Data Analysis Program

(Rev.675, Issued: 09-16-05, Effective: 10-01-05, Implementation: 10-03-05)
Effective: October 1, 2005

The basis of an effective quality improvement program is a Data Analysis program. Data analysis involves collecting relevant data, analyzing the data, identifying trends and aberrancies, and making conclusions based on the data collected. In order to perform adequate data analysis, whenever possible, contractors should use the entire universe of appeals to conduct the analysis. However, if contractors are unable to use the entire universe, contractors must, at a minimum, gather data from a 10 percent or 100 per month (whichever is less) randomly selected example of redeterminations. Data analysis should be performed, at minimum, on a monthly basis. Data analysis must be performed for each contractor site. Contractors may develop other approaches to data analysis if feasible, but these approaches must be submitted in writing to the servicing RO for approval before implementation. However, any changes to the process must result in the ability by the contractor to identify inefficiencies or problems with appeals; the original intent of the data analysis effort must not be compromised.

A. RO Examination of Redetermination Decision Letters

The fourth function of the Quality Improvement program involves RO examination of decision letters. At some point during the FY, the RO may contact contractors to make arrangements for a review of a sample of redetermination letters. The sample will consist of at least ten (10) of decision letters and will take place at the RO. The date of the review and quantity of the sample size are at the discretion of the RO. The RO may, at its discretion, arrange to review your decision letters at multiple times during the FY. The review is limited to the decision letter only.

The RO will evaluate all decision letters to determine:

- *Overall clarity, responsiveness, and accuracy*
- *Completeness of the summary of facts and issues*
- *Adequacy of the rationale/explanation of the decision*
- *Accuracy of reference to applicable laws regulations*

360 - Managing Appeals Workloads

(Rev.675, Issued: 09-16-05, Effective: 10-01-05, Implementation: 10-03-05)

360.1 - Standard Operating Procedures

(Rev.675, Issued: 09-16-05, Effective: 10-01-05, Implementation: 10-03-05)
Effective: October 1, 2005

The priorities set forth in this section are to be used by contractors as a guide in establishing standard operating procedures for managing an appeals workload when the budget amount is insufficient to adequately perform the required functions. In general, contractors should use a first-in, first-out method to process appeals and manage workload; however, during times of limited resources it may become necessary to prioritize the processing of appeals to more efficiently manage the workload. While CMS continues to recommend the priorities listed in this section, there may be instances where contractors find it more effective and efficient to prioritize in a different manner. Also, contractors may choose to establish standard operating procedures for managing an appeals workload that deviate from the priorities listed in this section. In both these cases, contractors should submit a copy of their prioritization plan to the regional office (RO) and obtain written approval from their RO for this variation within 30 days of the fiscal year.

360.2 - Execution of Workload Prioritization

(Rev.675, Issued: 09-16-05, Effective: 10-01-05, Implementation: 10-03-05)
Effective: October 1, 2005

A. Budget Related Workload Prioritization

Whenever it appears that the budget amount is insufficient to adequately perform the required functions and the need for additional funds can be adequately documented, contractors shall submit a Supplemental Budget Request (SBR) in accordance with the Medicare Financial Management Manual, chapter 2 §120. As a result of an SBR, or during the course of CMS' evaluation of a contractor's SBR, CMS may find it necessary that the contractor execute prioritization of workload in accordance with this section or in accordance with the contractor's standard operating procedures. The contractor should discuss possible alternatives for resolution in the SBR. If it becomes necessary to abate activities, contractors must submit proper notification in accordance with the terms of the Cost of Administration Article in the Contract/Agreement and begin processing work in accordance with this PM until a final agreement is reached between the contractor and CMS. As a result of an abatement, CMS may find it necessary that the contractor continue processing work in accordance with this manual instruction.

B. Other Circumstances That May Lead to Workload Prioritization

In circumstances other than those described above, it may become apparent that prioritization of workload is necessary because a contractor is unable to complete the

incoming or pending workload within the time frames described in this manual. In these situations the contractor must either consult with the RO immediately for guidance or inform their RO immediately that they plan to initiate their workload prioritization plan. An example of a situation that may lead to workload prioritization is an uncharacteristic, unanticipated increase in receipts over a two-month period, coupled with, insufficient staff or other resources that will impede you from completing the increased volume of appeals receipts in a timely manner.

360.3 - Workload Priorities

(Rev.675, Issued: 09-16-05, Effective: 10-01-05, Implementation: 10-03-05)

Effective: October 1, 2005

Priority 1-- Finalize effectuation of all redetermination, reconsideration, ALJ and Departmental Appeals Board (DAB) decisions and

Process redeterminations and forward reconsideration case files to the QIC timely on overpayment determinations (including Comprehensive Error Rate Testing (CERT) contractor appeals).

Priority 2-- Prepare, assemble, and forward case files to the QIC in accordance with the timeframes described in §320.6

Priority 3-- Adjudicate redeterminations from beneficiaries or their appointed beneficiary representatives in the timeframes described in §310.4.

Priority 4-- Adjudicate requests for redeterminations from providers, suppliers, or other appellants, including States or their third party agents, that are submitted <u>with</u> necessary documentation in the timeframes prescribed in §320.6.

Priority 5-- Adjudicate written requests for redeterminations from providers, suppliers, or other appellants, including States or their third party agents, that are submitted <u>without</u> necessary documentation in the timeframes prescribed in §320.6.